Department of HUMAN SERVICES

PCMH and Health Home Service Care Management

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This training is a collaborative effort between the Managed Care Organizations and Iowa Medicaid Enterprise

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AGENDA

1. Introductions
2. National Committee on Quality Assurance Patient Centered Medical Home (NCQA PCMH)……..……..……Pamela Lester IME
3. Health Home Case Study or Health Home Spotlight……Health Home
4. Open Discussion……..…All

   (Open discussion on current issues or barriers, potentially leading to future monthly topics)

Coming up:

Spring Learning Collaboratives:

- *April 12, 2021, Spring Learning Collaborative, Creating and Maintaining Relationships with Guardians and Providers, Guardians of NE Iowa*
- *April 12, 2021, Spring Learning Collaborative, How to collect your own data/Measures your own performance (Creating Action Plans to take home), Amerigroup*
- *April 19, 2021, Spring Learning Collaborative, Health Home Core Services and Roles, Iowa Total Care*
- *April 26, 2021, Spring Learning Collaborative,* Benefits of Health Homes/Interventions for members with SMI/SED, Amerigroup

Logistics

- Mute your line
- Do not put us on hold
- We expect attendance and engagement
- Type questions in the chat as you think of them and we will address them at the end.

Objectives

- Understand care management as it relates to PCMH and Health Home
- Identify PCMH and Health Home similarities between Comprehensive Assessment and Person-centered care plan
- Discuss quality improvement activities to meet the requirements of both

NCQA Terminology

- Care Management: Activities performed by Healthcare professionals to improve patient outcomes
- Care Plan: Individualized instructions and interventions given to the patient/family/caregivers and other providers in writing

Health Home Terminology

Comprehensive Care Management

The initial/ongoing assessment and care management services aimed at the integration of primary, behavioral/specialty healthcare, and community support services, using comprehensive person-centered care plan that addresses all clinical and non-clinical needs and promotes wellness and management of chronic conditions in pursuit of optimal health outcomes.

Why Care Management

- Accountable Care Organizations (ACOs)
  - Medicare Access and Chip Reauthorization Act (MACRA)
    - Chronic Care Management (CCM)
  - Private Payers
  - Medicaid
- Patient-Centered Medical Home Recognition
- Health Home Requirements

PCMH Criteria for CM

- Consider the following (CM-01)
  - Behavioral Health Conditions **
  - High Cost/High Utilization
  - Poorly Controlled or Complex Conditions**
  - Social Determinates of Health
  - Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff, patient/ family/caregiver
- % of total population (CM-02)
- Applies a comprehensive risk stratification process for the entire patient panel in order to identify and direct resources appropriately (CM-03)

Comprehensive Assessment PCMH

- KM-01 Up to date problem list with current and active diagnosis (MU) **
- KM-02 Comprehensive Health Assessment **
- KM-03 Depression screening adults and adolescents using a standardized tool (With follow-up Plan) **
- KM-04 Behavioral Health Screenings and/or assessments using a standardized tool **
- KM-05 Assesses oral health needs and provides necessary services during the care visit based on evidence-based guidelines or coordinates with oral health partners. **
- KM20 clinical decision support **

Health Home Comprehensive Assessment

- Assess the member's current and historical information provided by the member, the Lead Entity, and other health care providers that supports the member (KM-01, KM-02, KM-06)
- Includes a physical and behavioral assessment, medication reconciliation, functional limitations, appropriate screenings, completed by a licensed health care professional within 30 days of enrolling (KM-02, KM-03, KM-14)
- Member's social environment so that the plan of care incorporates areas of needs, strengths, preferences, and risk factors (KM-02)
- Member's readiness for self-management using screenings and assessments with standardized tools
- Conducted at least every 12 months or more frequently as needed when the member's needs or circumstances change significantly or at the request of the member or member's support
- Implementing a formal screening tool to assess behavioral health (mental health and substance abuse) treatment needs along with physical health care needs (KM-04)

Health Home Person-Centered Care Plan

- All patients identified for care management need to have a person-centered care plan (CM-04) **
  - To ensure that a care plan is meaningful, realistic and actionable, the practice involves the patient in the plan's development, which includes discussions about goals (e.g., patient function/life style, goal feasibility and barriers) and considers patient preferences.
  - Incorporates a problem list, expected outcome/ prognosis, treatment goals, medication management and a schedule to review and revise the plan, as needed. The care plan may also address community and/or social services.
  - updates the care plan at relevant visits. A relevant visit addresses an aspect of care that could affect progress toward meeting existing goals or require modification of an existing goal.
- Documents patient preference and functional/lifestyle goals in individual care plans (CM-06)
- Identifies and discusses potential barriers to meeting goals in individual care plans (CM-07)

Health Home Person-Centered Care Plan

- Includes a self-management plan in individual care plans (CM-08)
- Care plan is integrated and accessible across settings of care (CM-09)
- Creation of a person-centered care plans by a licensed health care professional with the member and individuals chosen by the member that address the needs of the whole person with input from the interdisciplinary team and other key providers organize, authorize and administer joint treatment planning with local providers, members, families and other social supports to address total health needs of members
- Wraparound planning process: identification, development and implementation of strengths-based individualized person-centered care plans addressing the needs of the whole person and family

Person-Centered Care Plan Shared

- Practice provides a care plan to patients/families/caregivers (CM 05)
- Care plan is integrated and accessible across settings of care (CM-09)

Quality Improvement

Understand Your Population

- Use your Electronic Medical Record (EMR) reporting system to identify predominate conditions and health concerns
  - Risk stratification
  - Diversity/cultural/language needs
  - Social Determinates of Health (SDOH) as structured data
  - Positive screenings and tests
  - Members with specific conditions
    - Health Home Conditions

Improve your Comprehensive Assessment

- Sara (AGP) created an excel of assessment questions
- Create as much structured data as possible
- The MCOs created a comprehensive assessment template
- US Preventative Services Task Force (USPSTF) https://www.uspreventiveservicestaskforce.org/uspstf/
- Bright Futures https://brightfutures.aap.org/Pages/default.aspx

Improve Your Person-Centered Care Plan

- Where is the care plan located in the patient record
- Ensure there are patient goals
- Document barriers
- Educational resources provided
- Ensure care plan prints with visit summary
- Structured data fields

Examples

Chief Complaint
F/U visit for ADD/ADHD:

History of Present Illness
Fever: None; Onset: >1 month; Duration: Chronic; Severity: Moderate; Quality: Improving
Academic performance: Mom states child is doing better in school
Overall behavior at home: Child's behavior has improved per mom
Overall behavior at school:

Assessment
DX 1: F90.2 Attention-deficit hyperactivity disorder, combined type
DX 2: Z79.899 Other long term (current) drug therapy
DX 3: R63.4 Abnormal weight loss

Plan
Reviewed with patient/family diagnosis, current medication regimen and medication side effects
Changes to current medication regimen:
Appropriate prescriptions written
Re-evaluate in: 3 weeks
recommend peanut butter,carnation instant breakfast-recheck wt in 3 weeks

Care Plan: Goals
- ADHD Management
- pediatric preventive health management
- Copy of ADHD

- Note is not completed
- No real care plan created
- Clinical summary not given to patient

You were seen in our office today for:
ADD maintenance visit

We discussed the following additional details about the reason for your visit:
Fever: None; Onset: >1 month
Academic performance:Pt is not currently in school
Overall behavior at home:Mother states pt is doing well at home
Overall behavior at school:Pt is not currently in school, summer break
Pt goal:To maintain level of behavior and concentration
Barrier: Summer break, not currently in school

We recorded the following vital signs and measurements:
Blood Pressure: 101 / 65 @10:16
Weight: ..... 53lb 8oz / 24.27kg (Low)
Height: ..... 52.8 in / 134.0 cm (5 %ile)
BMI: ..... 13.5 (Low)

Your identified problems/diagnoses today were:
DX 1: F90.0 ADHD, predominantly inattentive type
DX 2: Z79.899 Other long term (current) drug therapy

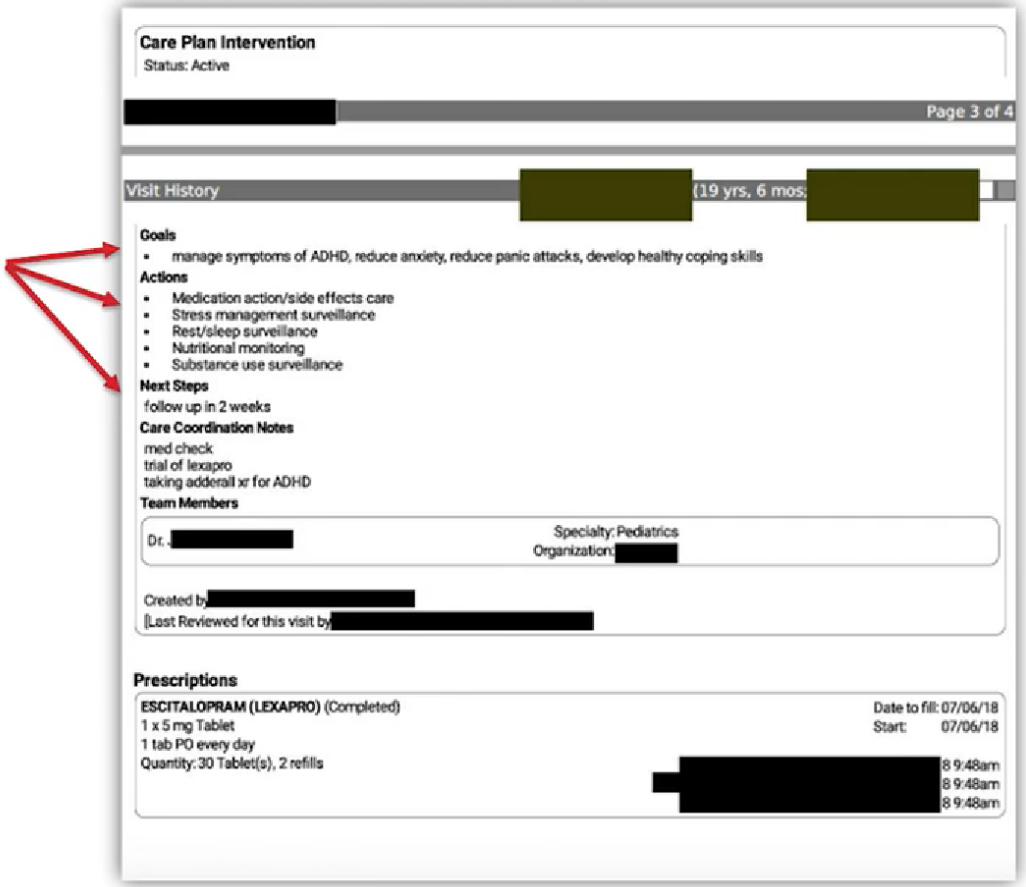
Our plan for your care includes:
Reviewed with patient/family diagnosis, current medication regimen and medication side effects
Changes to current medication regimen:none
Appropriate prescriptions written
Re-evaluate in: 6 months
Pt goal: to maintain attention and behavior
Barrier: Not currently in school

We discussed your care plan goals:
- ADHD Management
- pediatric preventive health management

- Added goals and barriers to template
- Data is in structured data fields
- Care plan has details
- Clinical summary & care plan given to patient

Example of Structured Data Fields

Structured Data Fields



Care Plan Intervention
Status: Active

[redacted] Page 3 of 4

Visit History [redacted] (19 yrs, 6 mos: [redacted]

Goals
- manage symptoms of ADHD, reduce anxiety, reduce panic attacks, develop healthy coping skills

Actions
- Medication action/side effects care
- Stress management surveillance
- Rest/sleep surveillance
- Nutritional monitoring
- Substance use surveillance

Next Steps
follow up in 2 weeks

Care Coordination Notes
med check
trial of lexapro
taking adderall xr for ADHD

Team Members
Dr. [redacted] Specialty: Pediatrics
Organization: [redacted]

Created by [redacted]
[Last Reviewed for this visit by [redacted]

Prescriptions
ESCITALOPRAM (LEXAPRO) (Completed)
1 x 5 mg Tablet
1 tab PO every day
Quantity: 30 Tablet(s), 2 refills
Date to fill: 07/06/18
Start: 07/06/18
[redacted] 8 9:48am
8 9:48am
8 9:48am

CCM Module (Detailed Care Plan)

Chronic Care Management (CCM)
Care Plans

SUMMARY FOR VISIT : 06/02/2018

Test , CCM
Account [redacted]

DOB: [redacted]

Ethnicity: Hispanic or Latino

Race: Other Race

Preferred Language: English

Visit Date: 06/02/2018 [redacted]

REASON FOR VISIT

- TEST

VITALS

- Init jmd
- Wt 135 (lbs)
- Ht 65 (in)
- Temp 99.8 (F)
- BP 130/80 (mm Hg)
- BMI 22.46 (Index)
- Ht-cm 165.1 (cm)
- Wt-kg 61.24 (kg)

ALLERGIES

- N.K.D.A.

TODAY'S DIAGNOSES INCLUDE

- E11.01: Type 2 diabetes mellitus with hyperosmolarity with coma
- I10: Accelerated hypertension
- F32.0: Mild major depression, single episode
- K21.9: Chronic GERD

Notes:

- Discussed diabetic retinopathy and how it is a chronic disease, often requiring multiple treatments with laser or other modalities to prevent further vision loss
  Blood pressure good, continue current medications
  Advised patient to decrease his caffeine intake. ,Advised patient to decrease his alcohol intake
  Medication side effects discussed with the patient

OTHER MEDICAL CONDITIONS (PROBLEM LIST)

ICD-9-CM Code	E11.01
Diagnosis	Type 2 diabetes mellitus with hyperosmolarity with coma
ICD-9-CM Code	I10
Diagnosis	Accelerated hypertension
ICD-9-CM Code	F32.0
Diagnosis	Mild major depression, single episode
ICD-9-CM Code	K21.9
Diagnosis	Chronic GERD

PREVENTIVE MEDICINE

- Counseling:
  Care goal follow-up plan: - Exercise Counseling Provided-: YesPatient received educational materials on physical activity-: YesAgreed upon exercise goal-: 1-2 times/weekBMI management provided: YesAbove Normal BMI Follow-up: Dietary management education, guidance, and counseling

CARE TEAM

- [redacted]

Sample self-management tools

- Asthma action plan
- Something that empowers patients to take care of their health based on their self-management goals.
- Self-check plan
- Apps and websites

Social Determinates of Health (SDOH)

- Economic Stability
- Education
- Health and Health Care
- Neighborhood and Build Environment
- Social and Community Context

Healthy People.gov for ways to address SDOH

https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources#

Title: Improving Care Management

Purpose/AIM

ABC Health Home aims to improve Care Management for our population to improve patient outcomes.

Background

ABC Health Home has identified the need to better assess and plan patient's care.

Current Process

ABC Health Home has the PCP complete an assessment and plan. The Health Coach/Nurse Care Manager identifies gaps in care and coordinates a patient's care when they request.

Causes

QA process determined that we have opportunities to approve the assessment and plan of care for members ensuring that all members of the care team work to their highest level and within their scope of practice.

Assessment: lacked consistent documentation of SDOH and risk assessment. Overall score on our assessment section was 55%

PCCP: lacked being member driven, reflecting members strengths, preferences as well as all of their needs. Overall score on our pare plan section was 33%

Future Process

Team members will assess all patients for SDOH along with a risk assessment to improve how we identify patients in need of care management.
For patients identified for care management, the nurse care manager and Health Coach will utilize the person-centered planning process to develop a patient-centered care plan based on the assessment and the patient's identified needs.

Action Plans

<u>Tasks</u>

- Make changes in our templates to easily capture assessment information as structured data.
  - Who/ When
- Staff Training on risk assessment, SDOH assessments including how to document.
  - Who/When
- Staff training on the person-centered planning process.
  - Who/When

Outcomes

A smaller PDSA has been used to identify areas of opportunities around the 3 identified tasks. This will continue until we meet our goal of 95% achievement in our assessment and care plan section of our QA documentation review.

Follow up

Documentation has improved and we have met our goal of 95% in the assessment and care plan section of our QA file review.
We have also improved our outcomes measures

- Diabetes control 86% from 80%
- Controlling High Blood pressure

Our staff have noticed an increase in patient engagement through the implementation of the person-centered planning process. Which we believe can be attributed to our improved outcomes.

Questions?

Open Discussion